

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>012288</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/11/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAMPLIGHT INN OF FORT WAYNE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>300 E WASHINGTON BLVD FORT WAYNE, IN 46802</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Complaints IN00117111 and IN00117214.</p> <p>Complaint IN00117111- Unsubstantiated due to lack of evidence. Complaint IN00117214- Unsubstantiated due to lack of evidence.</p> <p>Survey date: October 11, 2012</p> <p>Facility number: 012288 Provider number: 012288 AIM number: N/A</p> <p>Survey team: Diane Nilson, RN, TC Angela Strass, RN</p> <p>Census bed type: Residential: 116 Total: 116</p> <p>Census payor type: Other: 116 Total: 116</p> <p>Sample: 3</p> <p>Lamplight Inn of Fort Wayne was found to be in compliance with 410 IAC 16.2 in regard to Investigation of Complaints IN00117111 and IN00117214.</p> <p>Quality review 10/12/12 by Suzanne Williams, RN</p>	R 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

JMDX11

If continuation sheet 1 of 1